FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007344

Facility Name: CARROLL COUNTY GOOD SAMARITAN CENTER

Address: BOX 111 N WASHINGTON (Number) MOUNT CARROLL (City) 61053 (Zip Code)

County: CARROLL

Telephone Number: (815)244-7715 **Fax #** (815)244-3127

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners: 1/1/70

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605) 362-3100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 3/25/03

(Type or Print Name) RAYE NAE NYLANDER

(Title) VICE PRESIDENT

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,647	11,060	1,028	24,735	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,647	11,060	1,028	24,735	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.12%

D. How many bed-hold days during this year were paid by Public Aid?
26 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 821

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,279	13,781	6,114	158,174		158,174		158,174			1
2	Food Purchase		112,262		112,262		112,262	(9,104)	103,158			2
3	Housekeeping	47,201	16,211		63,412		63,412		63,412			3
4	Laundry	38,885	11,264		50,149		50,149		50,149			4
5	Heat and Other Utilities			66,382	66,382		66,382		66,382			5
6	Maintenance	46,638	11,467	33,694	91,799		91,799	(3,088)	88,711			6
7	Other (specify):*			906	906		906	(133)	773			7
8	**TOTAL General Services**	271,003	164,985	107,096	543,084		543,084	(12,325)	530,759			8
	B. Health Care and Programs											
9	Medical Director	875,223	69,914	252,538	1,197,675		1,197,675		1,197,675			9
10	Nursing and Medical Records	31,319	612	29,255	61,186	(2,057)	59,129	(20,546)	38,583			10
10a	Therapy	58,594	2,393	9,552	70,539		70,539	(13,453)	57,086			10a
11	Activities	32,564		3,742	36,306		36,306	(4,494)	31,814			11
12	Social Services											12
13	Nurse Aide Training					2,057	2,057		2,057			13
14	Program Transportation			832	832	171	1,003		1,003			14
15	Other (specify):*	33,285			33,285		33,285		33,285			15
16	**TOTAL Health Care and Programs**	1,030,985	72,919	295,919	1,399,823	171	1,399,994	(38,493)	1,361,503			16
	C. General Administration											
17	Administrative	51,451		106,605	158,056		158,056	26,332	184,388			17
18	Directors Fees											18
19	Professional Services			1,000	1,000		1,000		1,000			19
20	Dues, Fees, Subscriptions & Promotions			8,923	8,923		8,923	(4,428)	4,495			20
21	Clerical & General Office Expenses	60,501	16,196	20,706	97,403		97,403	(574)	96,829			21
22	Employee Benefits & Payroll Taxes			319,778	319,778		319,778	8,936	328,714			22
23	Inservice Training & Education			9,569	9,569		9,569		9,569			23
24	Travel and Seminar			4,818	4,818	(171)	4,647		4,647			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,329	28,329		28,329	3,216	31,545			26
27	Other (specify):*	14,166		446	14,612		14,612	(14,166)	446			27
28	**TOTAL General Administration**	126,118	16,196	500,174	642,488	(171)	642,317	19,316	661,633			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,428,106	254,100	903,189	2,585,395		2,585,395	(31,502)	2,553,895			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER #0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			151,070	151,070		151,070		151,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			455	455		455	(455)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,849	6,849		6,849		6,849			35
36	Other (specify):*											36
37	**TOTAL Ownership**			158,374	158,374		158,374	(455)	157,919			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			275	275		275	(275)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,420	39,420		39,420		39,420			42
43	Other (specify):*			1,872	1,872		1,872	(1,872)				43
44	**TOTAL Special Cost Centers**			41,567	41,567		41,567	(2,147)	39,420			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,428,106	254,100	1,103,130	2,785,336		2,785,336	(34,104)	2,751,234			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,104)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,494)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,428)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,990)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,471)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	39,367		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 39,367		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (34,104)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CARROLL COUNTY GOOD SAMARITAN CENTER

ID# 0007344

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SALARIES - RES DEV	$ (14,393)	27	1
2	ADMINISTRATION	(30)	21	2
3	VAC ACC - RES DEV	227	27	3
4	POSTAGE	(98)	21	4
5	RESIDENT SUPPLIES	(133)	7	5
6	Deferred Maint Costs - 2001	420	6	6
7	PRESCR DRUGS - REIMB	(14,288)	10	7
8	BARBER/BEAUTY EXPENSES	(275)	40	8
9	MISC FDRAISERS EXP - RES DEV	(446)	21	9
10	THERAPY OFFSET - PT, OT, ST	(13,453)	10A	10
11	PURCH SVC - LABORATORY	(1,017)	43	11
12	PURCH SVC - RADIOLOGY	(855)	43	12
13	FICA - RES DEV	(883)	22	13
14	MARKETING SUPPLIES		21	14
15	INOCULATION		10	15
16	GLUCOSE STRIP EXP	(3,593)	10	16
17	Deferred Maint Costs - 2002	(2,723)	6	17
18	TRANSPORTATION	(785)	6	18
19	PROCLAIM OFFSET	(2,665)	10	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,990)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,104)	0	0	0	0	0	0	0	0	0	0	(9,104)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,088)	0	0	0	0	0	0	0	0	0	0	(3,088)	6
7	Other (specify):*	(133)	0	0	0	0	0	0	0	0	0	0	(133)	7
8	**TOTAL General Services**	(12,325)	0	0	0	0	0	0	0	0	0	0	(12,325)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20,546)	0	0	0	0	0	0	0	0	0	0	(20,546)	10
10a	Therapy	(13,453)	0	0	0	0	0	0	0	0	0	0	(13,453)	10a
11	Activities	(4,494)	0	0	0	0	0	0	0	0	0	0	(4,494)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(38,493)	0	0	0	0	0	0	0	0	0	0	(38,493)	16
	C. General Administration													
17	Administrative	0	26,332	0	0	0	0	0	0	0	0	0	26,332	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,428)	0	0	0	0	0	0	0	0	0	0	(4,428)	20
21	Clerical & General Office Expenses	(574)	0	0	0	0	0	0	0	0	0	0	(574)	21
22	Employee Benefits & Payroll Taxes	(883)	9,819	0	0	0	0	0	0	0	0	0	8,936	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,216	0	0	0	0	0	0	0	0	0	3,216	26
27	Other (specify):*	(14,166)	0	0	0	0	0	0	0	0	0	0	(14,166)	27
28	**TOTAL General Administration**	(20,051)	39,367	0	0	0	0	0	0	0	0	0	19,316	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,869)	39,367	0	0	0	0	0	0	0	0	0	(31,502)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(455)	0	0	0	0	0	0	0	0	0	0	(455)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(455)	0	0	0	0	0	0	0	0	0	0	(455)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(275)	0	0	0	0	0	0	0	0	0	0	(275)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,872)	0	0	0	0	0	0	0	0	0	0	(1,872)	43
44	**TOTAL Special Cost Centers**	(2,147)	0	0	0	0	0	0	0	0	0	0	(2,147)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,471)	39,367	0	0	0	0	0	0	0	0	0	(34,104)	45

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ev Lutheran	100%					
Good Samaritan Society						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin Acctg	$ 106,605	The Ev Lutheran Good Samaritan Society	100.00%	$ 132,937	$ 26,332	1
2	V	22	Workers Comp	51,569			38,111	(13,458)	2
3	V	22	Unemploy Charges Paid	9,674			9,834	160	3
4	V	26	Insurance	28,329			31,545	3,216	4
5	V	22	Group Health/Life Insurance	122,660			145,777	23,117	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 318,837			$ 358,204	$ * 39,367	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1			NOT APPLICABLE						$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The EV Lutheran Good Samaritan Society
Street Address: 4800 W 57th, P.O. Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: (605)362-3100
Fax Number: (605)362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2				NO ALLOCATION NECESSARY						2
3										3
4			SEE REPORT ON ALLOWABLE CENTRAL OFFICE EXPENSES FOR THE YEAR ENDED DECEMBER 31, 2002							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Annuities					Various	5,000	5,000			455	6
7												7
8												8
9	TOTAL Facility Related						$ 5,000	$ 5,000			$ 455	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,000	$ 5,000			$ 455	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	1,555	9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARROLL COUNTY GOOD SAMARITAN CENTER COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0007344

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1970	1970	$ 418,768	$ 10,470	40	$ 10,470	$	$ 344,610	4
5			1991	1991	912,129	39,246	Varies	39,246		606,842	5
6											6
7											7
8											8
	Improvement Type**										
9	Building										9
10											10
11				1971	382	9	varies	9		301	11
12				1976	3,352		varies			3,352	12
13				1979	5,570		varies			5,570	13
14				1980	1,419		varies			1,419	14
15				1981	33,937		varies			33,627	15
16				1982	29,187	592	varies	592		29,187	16
17				1983	8,193	410	varies	410		7,841	17
18				1984	1,224		varies			1,224	18
19				1985	14,500	725	varies	725		12,446	19
20				1986	11,402	55	varies	55		11,227	20
21				1987	15,273	543	varies	543		12,661	21
22				1988	14,405	673	varies	673		10,881	22
23				1989	35,790	2,326	varies	2,326		31,964	23
24				1990	24,930	1,599	varies	1,599		21,378	24
25											25
26				1992	10,950	518	varies	518		6,293	26
27				1993	2,434	243	varies	243		2,390	27
28				1994	48,103	3,903	varies	3,903		34,363	28
29				1995	36,886	3,621	varies	3,621		28,627	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building			$		$	$	$	37
38	Compressor/Control Board	1996	2,027	135	15	135		946	38
39	Air Conditioning	1996	98,766	6,584	15	6,584		46,091	39
40	Return Air Ducts	1996	1,030	52	20	52		339	40
41	Roof	1996	75,405	3,770	20	3,770		23,878	41
42	Installation of Annumciator	1997	7,151		6			7,151	42
43	Installation of New Ambulance	1997	1,924	128	15	128		652	43
44	Replaced Roof	1997	11,920	596	20	596		3,030	44
45	Hand Rails	1998	5,049	337	15	337		1,627	45
46	Electric-Emergency Panel	1998	4,300	215	20	215		1,075	46
47	Wiring For Network	1998	6,096	305	20	305		1,295	47
48	Repair Roof	1998	1,325	132	10	132		563	48
49	Steel Door	1999	2,284	152	15	152		596	49
50	Alarm System	1999	20,000	2,000	10	2,000		6,833	50
51	Alarm System	1999	8,080	404	20	404		1,246	51
52	Electric-Maint Storage Building	2000	2,100	105	20	105		315	52
53	Maintenance Storage Building	2000	20,196	505	40	505		1,515	53
54	Water Heater	2000	3,500	350	10	350		963	54
55	Water Heater	2000	1,639	164	10	164		465	55
56	Piping & Wiring-Dishwasher	2000	2,180	218	10	218		563	56
57	Painting in Kitchen	2000	2,126	425	5	425		1,063	57
58	Building-Interior Renovations	2000	2,800	112	25	112		289	58
59	Painting-Interior Renovations	2000	637	128	5	128		329	59
60	Wallpaper-Interior Renovations	2000	15,389	3,078	5	3,078		7,951	60
61	Extensions of Firewall	2000	3,985	199	20	199		448	61
62	Carpet-Interior Renovation	2000	26,529	5,306	5	5,306		13,707	62
63	Oak Doors	2002	3,545	177	15	177		177	63
64	Wiring Redpt For Call Light	2002	663	11		11		11	64
65	Vertical Blinds	2002	510	17		17		18	65
66	Restroom Remodeling	2002	385	6		6		6	66
67	Window Replacement-Resident Rm	2002	28,542	317		317		317	67
68	Commercial Door	2002	509	6		6		6	68
69	Tile	2002	536	5		5		5	69
70	TOTAL (lines 4 thru 69)		$ 1,989,962	$ 90,872		$ 90,872	$	$ 1,329,673	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,989,962	$ 90,872		$ 90,872	$	$ 1,329,673	1
2	Building								2
3	Open Front Toilet Seat	2002	568	5	20	5		5	3
4	Land Improvements								4
5		1970	3,703		15			3,703	5
6		1975	1,986		15			1,986	6
7		1977	185		15			185	7
8		1979	466		15			466	8
9		1980	140		15			140	9
10		1986	3,061		10			3,061	10
11		1988	3,474	232	15	232		3,261	11
12		1989	1,419		10			1,419	12
13		1991	98,154	5,875	varies	5,875		76,981	13
14		1993	2,560	256	10	256		2,324	14
15		1994	20,508	1,526	varies	1,526		12,600	15
16	Seal Cost Driveways and Parking	1997	3,050	153	20	153		839	16
17	Paving-Additional Parking Lot	1999	6,640	332	20	332		1,107	17
18	Lumber for Raised Garden	2000	330	33	10	33		85	18
19	Garden Beds	2000	1,650	110	15	110		275	19
20	Shrubs	2000	677	68	10	68		164	20
21	Driveway Repair	2000	4,455	446	10	446		1,040	21
22	Landscaping	2000	392	26	15	26		61	22
23	Repair Sidewalk	2002	4,270	178	10	178		178	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,147,650	$ 100,112		$ 100,112	$	$ 1,439,553	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTI# 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 453,574	$ 39,875	$ 39,875	$		$ 202,493	71
72	Current Year Purchases	36,503	2,146	2,146			2,146	72
73	Fully Depreciated Assets	178,762					178,762	73
74								74
75	TOTALS	$ 668,839	$ 42,021	$ 42,021	$		$ 383,401	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1978 Jeep Truck W/Snow Plow	2000	$ 2,500	$ 625	$ 625	$	4	$ 1,354	76
77		Bus	2002	42,763	5,939	5,939		6	5,940	77
78										78
79										79
80	TOTALS			$ 45,263	$ 6,564	$ 6,564	$		$ 7,294	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,867,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,697	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,697	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,830,248	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,849 Description: Network Computer Euip-Admin, Technicare-Nursing
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,152	$	$ 1,152
2	Books and Supplies			30		30
3	Classroom Wages	(a)		463		463
4	Clinical Wages	(b)		232		232
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			180		180
9	TOTALS		$	$ 2,057	$	$ 2,057
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,057			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, col 3	1030 hrs	$ 12,137		$	$	1,030	$ 12,137	1
2	Licensed Speech and Language Development Therapist	10a, col3	1153 hrs	13,324				1,153	13,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, col 3	255 hrs	3,003				255	3,003	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 28,464		$	$	2,438	$ 28,464	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 44,538	$	1
2	Cash-Patient Deposits	4,972		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)	14,037		4
5	Short-Term Investments	1,294,050		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	461,846		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,819,443	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	1,990,530		14
15	Leasehold Improvements, at Historical Cost	157,120		15
16	Equipment, at Historical Cost	714,102		16
17	Accumulated Depreciation (book methods)	(1,830,246)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	98,232		21
22	Other Long-Term Assets (specify):	5,702		22
23	Other(specify):	38,772		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,179,932	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,999,375	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,333	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	205,274		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,276		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Group Ins-Employee Portion	(202)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 409,681	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuities	5,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 414,681	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,584,694	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,999,375	$	48

***(See instructions.)**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,833,617	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,833,617	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(136,591)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **DNR RST END-GEN, DNR RST OPER**	(33,130)	15
16	Other (describe) **INTRA-CO N/A-CO**	(79,202)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (248,923)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,584,694	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CEN # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,053,017	1
2	Discounts and Allowances for all Levels	(593,055)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,459,962	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	124,117	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 124,117	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	793	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,361	19
20	Radiology and X-Ray	601	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,003	23
	D. Non-Operating Revenue		
24	Contributions	43,444	24
25	Interest and Other Investment Income***	(71,802)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (28,358)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nsg & Med Supplies	24,197	28
28a	Schedule Attached	15,823	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,020	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,648,744	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	543,084	31
32	Health Care	1,399,823	32
33	General Administration	642,488	33
	B. Capital Expense		
34	Ownership	158,374	34
	C. Ancillary Expense		
35	Special Cost Centers	41,566	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,785,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	(136,591)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (136,591)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,913	2,088	$ 41,200	$ 19.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,403	13,846	256,524	18.53	3
4	Licensed Practical Nurses	5,148	5,689	91,833	16.14	4
5	Nurse Aides & Orderlies	32,833	49,767	422,617	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,302	3,536	40,434	11.43	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,846	2,072	22,853	11.03	9
10	Activity Assistants	4,371	4,834	35,635	7.37	10
11	Social Service Workers	2,545	2,686	32,770	12.20	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,098	22,564	10.76	13
14	Head Cook	7,192	8,184	56,638	6.92	14
15	Cook Helpers/Assistants	8,024	8,844	58,217	6.58	15
16	Dishwashers					16
17	Maintenance Workers	1,933	5,098	46,222	9.07	17
18	Housekeepers	6,886	7,515	46,812	6.23	18
19	Laundry	4,334	4,875	38,736	7.95	19
20	Administrator	1,880	2,088	50,669	24.27	20
21	Assistant Administrator					21
22	Other Administrative	5,880	6,577	83,740	12.73	22
23	Office Manager	727	834	8,588	10.30	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,140	3,741	50,082	13.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,230	134,372	$ 1,406,134 *	$ 10.46	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 5,502	Ln 10, Col 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	73	3,281	Ln 10, Col 3	39
40	Physical Therapy Consultant	255	3,003	Ln 10, Col 3	40
41	Occupational Therapy Consultant	1,030	12,137	Ln 10, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,153	13,324	Ln 10, Col 3	43
44	Activity Consultant	51	2,763	Ln 10, Col 3	44
45	Social Service Consultant	58	3,161	Ln 10, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,747	$ 43,171		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6	$ 246	Ln 10, Col 3	50
51	Licensed Practical Nurses	1,756	71,210	Ln 10, Col 3	51
52	Nurse Aides	8,975	185,592	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	10,737	$ 257,048		53

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENT # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrator	100	$ 50,669
Vacation Accrual			782
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,451

B. Administrative - Other

Description	Amount
Admin & Acctng Srvs	$ 106,605
TOTAL (agree to Schedule V, line 17, col. 3)	$ 106,605
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Medicare Cost Report Prep	$ 500
	Medicaid Cost Report Prep	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,000

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,111
Unemployment Compensation Insurance	9,834
FICA Taxes	106,594
Employee Health Insurance	145,777
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Pension	26,732
Employee Physicals	29
Res Dev FICA	(883)
Taxable Gifts	50
Admin Consultant Savings	1,900
Employee Recruitment - Nursing	570
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,714

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,562
Health Care Worker Background Check	
(Indicate # of checks performed)	
Public Relations	379
Dues - Reimbursable	982
Less: Public Relations - Reimb	(436)
Less: Advertising/Promo - Admin	(3,992)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,495

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,140
In-State Travel	2,685
Seminar Expense	822
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,647

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	HEATING	01/02	$ 1,738	10	$	$	$	$ 174	$ 174	$ 174	$ 174	$ 174	$ 174
2	HEATING	04/02	1,288	10				129	129	129	129	129	129
3	HEATING	1/01	$ 219	10	$	$	$	$ 22	$ 22	$ 22	$ 22	$ 22	$ 22
4	PLUMBING	2/01	910	10				83	91	91	91	91	91
5	WALLPAPER	7/01	230	5				24	61	61	61	23	
6	PAINT	8/01	390	5				35	102	102	102	49	
7	AIR CONDITIONING	9/01	511	10				17	51	51	51	51	51
8	AIR CONDITIONING	10/01	1,841	10				46	184	184	184	184	184
9	AIR CONDITIONING	2/01	901	10				75	90	90	90	90	90
10	PLUMBING	4/01	87	10				7	9	9	9	9	9
11	PLUMBING	4/01	579	10				43	58	58	58	58	58
12	HEATING	5/01	152	10				10	15	15	15	15	15
13	PLUMBING	8/01	1,402	10				58	140	140	140	140	140
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,248		$	$	$	$ 723	$ 1,126	$ 1,126	$ 1,126	$ 1,035	$ 963

Facility Name & ID Number CARROLL COUNTY GOOD SAMARITAN CENTER # 0007344 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $982**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,017** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **39,420**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **9,103**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **4%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HENRY SCHOLTEN & COMPANY** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.